PATIENT TRANSFER REPORTING FORM

(Pursuant to Business and Professions Code Section 2240)

1. Name of Patient's Outpatient Setting Physician:
Last _____ First _____ Middle
Physician's License Number:

2. Name of Physician with Hospital Privileges (if the same as above, leave blank):
Last _____ First _____ Middle

Physician's License Number:

Medical Record Number: _____

3. Patient Name:
Last _____ First _____ Middle

Address: _____ Date of Birth: _____
Number Street City State ZIP Code

3a. Patient Identifier (Social Security Number, Patient ID Number, etc.):

4. Name and Address of Hospital or Emergency Center where Patient was Transferred:

State law (Section 2240(b) of the California Business and Professions Code) requires that a completed copy of this entire form be placed in a patient's file. After completing the form, make 2 photocopies of the full form. Send 1 copy to the facility identified in #4 above for insertion in the patient's record. With the second copy, cut on line and mail the bottom portion within 15 days of the transfer to:

Office of Statewide Health Planning and Development
Patient Data Section
Attn: Physician Reporting-Transfers
400 R Street, Suite 270
Sacramento, CA 95814

**As of January 1, 2002 per B&P Code 2240, this form should be mailed to the Office of Statewide Health Planning and Development.*

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5. Specific Procedure(s) Performed:

5a. _____ Sex of Patient _____ Age of Patient _____ County of Surgical Setting

6. Transfer for postoperative care was planned and arranged with hospital prior to surgery: ____ yes ____ no

6a. Events triggering/necessitating transfer (including pre-arranged post operative care): ____ respiratory distress ____ drug reaction ____ cardiovascular distress ____ excessive bleeding ____ other (please specify)

Details of event (Please attach explanation if more space is needed and include in patient's chart and mailing to the Office of Statewide Health Planning and Development).

7. Duration of Hospital Stay:

____ Day(s) _____ Week(s) _____ Month(s)

8. Final Disposition: ____ Patient Died

_____ Patient Sent Home ____ Other (please specify)

9. Physician Practice Specialty and ABMS Certification:

Date of Report: _____